July 27, 2010

RE: **Acute Care Hospital – Obstetrics and Gynecological Services**
Hospital Provider Letter A-243

Dear Kentucky Medicaid Provider:

Effective September 1, 2010 the Department for Medicaid Services is enhancing the Obstetrics and Gynecology services authorization process to include the requirement of additional clinical data for all Medicaid recipient births.

This new information is required for every prior authorization request for a birth and must be received before the mother's authorization will be activated for billing. Attached is the Obstetric Notification form which contains the required information. Missing information will prevent the request from being processed. All fields are mandatory and "NA" should be used to populate fields considered "not applicable".

The Obstetric Notification information can be phoned or faxed to SHPS
- Phone: (800) 292-2392
- Fax: (502) 429-5233 or (800) 807-8843

If you have questions about this process, please contact SHPS at (800) 292-2392. We appreciate your cooperation and support of our effort to improve service to our providers and the recipients in the Commonwealth.

Sincerely,

Elizabeth A. Johnson
Commissioner

OBSTETRIC NOTIFICATION FORM
PHONE (800) 292-2392   FAX (800) 807-8843

Recipient Information Section				
Recipient Name		**Recipient ID**		
Recipient DOB				
Recipient Address		**City/State/Zip**		

Facility Information Section			
Facility Name		**Facility ID**	
Facility Address		**City/State/Zip**	

MD Information Section		
MD Name		
MD Address		**City/State/Zip**
MD Phone		

OB Information Section						
Admit Date-Time	-	**Type:**	☐ Urgent		☐ Scheduled	
Admit ICD-9 DX	.	**ICD-9 Proc. Code**	.		**Proc. Date**	
Primary ICD-9 DX	.	**ICD-9 Proc. Code**	.		**Proc. Date**	
Second. ICD-9 DX	.	**ICD-9 Proc. Code**	.		**Proc. Date**	

Clinical Information					
EDC		*(mm/dd/yy)*	**Gestational Age**		*weeks*
Gravida	.		**Para**		
Outcome	☐ C-Section		☐ Normal Vaginal Delivery	☐ Other:	
Sex	☐ Male		☐ Female		
Delivery Date		*(mm/dd/yy)*		**Delivery Time**	
Birth Weight		*grams*	**Apgars**	1 Minute	5 Minutes

For Cesarean Sections ONLY – Document Reason For The C-Section

Describe Pre-Delivery Hospital Care: (Include All Stages Of Labor)

Contact Information	
Contact Name	
Contact Telephone Number	
Contact Fax Number	

Form version 1.0 (December 2009)